APPENDICES

APPENDIX A-1 PLAN 5 MEDICAL PLAN INDIVIDUAL SCHEDULE OF BENEFITS

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
Florida Municipal Insurance Trust HSA Medical Plan **5**

United HealthCare Services, Inc. and Florida Municipal Insurance Trust want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Individual Deductible Family Deductible	$1,300 per year $2,600 per year	$2,500 per year $5,000 per year
•		
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$3,750 per year $7,500 per year	$7,500 per year $15,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.		
Information of Pre-service Notification		
**Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)* ***Prior Authorization is required for Equipment in excess of $1,000.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Dental Services – Accident Only		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	90% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	90% after Deductible has been met	* 90% after Network Deductible has been met

SFXGFTTT07PA

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	90% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met	* 70% after Deductible has been met
Hospice Care		
	90% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	90% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	90% after Deductible has been met	70% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
		Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	90% after Deductible has been met	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited	90% after Deductible has been met	70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	90% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Surgery – Outpatient		
	90% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 90% after Deductible has been met	Non-Network Benefits are not available
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	90% after Deductible has been met	70% after Deductible has been met

MEDICAL EXCLUSIONS

It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded,: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Use Disorder

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat

accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

APPENDIX A-2 PLAN 5 MEDICAL PLAN FAMILYSCHEDULE OF BENEFITS

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
Florida Municipal Insurance Trust HSA Family Medical Plan **5**

United HealthCare Services, Inc. and Florida Municipal Insurance Trust want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Individual Deductible Family Deductible	$2,600 per year $2,600 per year	$2,500 per year $5,000 per year
•		
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$3,750 per year $7,500 per year	$7,500 per year $15,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met.		
Information of Pre-service Notification		
**Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)* ***Prior Authorization is required for Equipment in excess of $1,000.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Dental Services – Accident Only		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	90% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	90% after Deductible has been met	* 90% after Network Deductible has been met

SFXGFTTT07PA

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	90% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met	* 70% after Deductible has been met
Hospice Care		
	90% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	90% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	90% after Deductible has been met	70% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
		Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	90% after Deductible has been met	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited	90% after Deductible has been met	70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	90% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Surgery – Outpatient		
	90% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 90% after Deductible has been met	Non-Network Benefits are not available
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	90% after Deductible has been met	70% after Deductible has been met

MEDICAL EXCLUSIONS

It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded,: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Use Disorder

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat

accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dysiexia.

APPENDIX A-3 PLAN 5 MEDICAL PLAN PRESCRIPTION SCHEDULE OF BENEFITS

UnitedHealthcare®

Benefit Summary
Outpatient Prescription Drug
Florida Municipal Insurance Trust Pharmacy Plan - HSA

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. All Prescription Drugs on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling Customer Care at the telephone number on the back of your ID card

A deductible and out-of-pocket maximum may apply. Please refer to the medical plan documents for the annual deductible and out-of-pocket maximum amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your copayment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the copayments outlined below. If you reach the Out-of-Pocket maximum, you will not be required to pay a copayment.

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

Annual Drug Deductible – Network and Non-Network	
Individual Deductible	See Medical Benefit Summary
Family Deductible	See Medical Benefit Summary
Out-of-Pocket Drug Maximum – Network and Non-Network	
Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	$10	$10	$25
Tier 2	$35	$35	$87.50
Tier 3	$60	$60	$150

* Only certain Prescription Drugs are available through mail order; please visit **www.myuhc.com®** or call Customer Care at the telephone number on the back of your ID card for more information.

An Ancillary Charge may apply when a covered Prescription Drug is dispensed at your [or your provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

Note: If you purchase a Prescription Drug from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug dispensed by a Network Pharmacy.

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits

Some Prescription Drug or Pharmaceutical Products for which Benefits are described under the Prescription Drug section of the Summary Plan Description (SPD) are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drugs require that you notify us in advance to determine whether the Prescription Drug meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drugs dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless United HealthCare Services, Inc. and the Florida Municipal Insurance Trust have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drugs for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that Florida Municipal Insurance Trust determine do not meet the definition of a Covered Health Service.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs when prescribed to treat infertility.
- Certain Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.

- A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

APPENDIX A-4 PLAN 14 MEDICAL PLAN SCHEDULE OF BENEFITS

UnitedHealthcare®

Benefit Summary
ASO Choice Plus
Florida Municipal Insurance Trust Medical Plan **14**

United HealthCare Services, Inc. and Florida Municipal Insurance Trust **want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:**

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible Family Deductible	$1,000 per year $2,000 per year	$1,000 per year $2,000 per year
• Member Copayments do not accumulate towards the Deductible		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum Family Out-of-Pocket Maximum	$4,000 per year $8,000 per year	$6,000 per year $12,000 per year
• The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover.		
Information of Prior Authorization		
**Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)* ***Prior Authorization is required for Equipment in excess of $1,000.*		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 80% after Deductible has been met	* Same as Network
Dental Services – Accident Only		
	* 80% after Deductible has been met	* Same as Network
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	80% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	100% after you pay a $200 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	* 100% after you pay a $200 Copayment per visit

SFXGMTTT07PA

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: $2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.	* 70% after Deductible has been met
Hospice Care		
	80% after Deductible has been met.	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	80% after Deductible has been met.	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% Deductible does not apply.	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a $25 Copayment per visit	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a $25 Copayment per visit	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	100% Deductible does not apply	70% Deductible does not apply
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $25 Copayment per visit	* 70% after Deductible has been met
Specialist Physician Office Visit	100% after you pay a $50 Copayment per visit	* 70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	*Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		Prior Authorization is required for certain services.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	100% after you pay a $25 Copayment per visit	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a $25 Copayment per visit	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Surgery – Outpatient		
	80% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 80% after Deductible has been met	Non-Network Benefits are not available
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	100% after you pay a $35 Copayment per visit	70% after Deductible has been met

MEDICAL EXCLUSIONS
It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded,: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.

Experimental or Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Use Disorder

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan
Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.
Transplants
Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).
Travel
Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.
Types of Care
Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
Vision and Hearing
Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
All Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

APPENDIX A-5 PLAN 14 MEDICAL PLAN PRESCRIPTION SCHEDULE OF BENEFITS

UnitedHealthcare®

Benefit Summary
Outpatient Prescription Drug
Florida Municipal Insurance Trust Pharmacy Plan - Choice Plus

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. All Prescription Drugs on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling Customer Care at the telephone number on the back of your ID card

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

Annual Drug Deductible – Network and Non-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible
Out-of-Pocket Drug Maximum – Network and Non-Network	
Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	$10	$10	$25
Tier 2	$35	$35	$87.50
Tier 3	$60	$60	$150

* Only certain Prescription Drugs are available through mail order; please visit **www.myuhc.com®** or call Customer Care at the telephone number on the back of your ID card for more information.

An Ancillary Charge may apply when a covered Prescription Drug is dispensed at your [or your provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

Note: If you purchase a Prescription Drug from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug dispensed by a Network Pharmacy.

SFXRPTTT07PA

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits

Some Prescription Drug or Pharmaceutical Products for which Benefits are described under the Prescription Drug section of the Summary Plan Description (SPD) are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drugs require that you obtain prior authorization from us in advance to determine whether the Prescription Drug meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

You may be required to fill an initial Prescription Drug Product order and obtain on refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- .Prescription Drugs dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless United HealthCare Services, Inc. and the Florida Municipal Insurance Trust have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drugs for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that Florida Municipal Insurance Trust determine do not meet the definition of a Covered Health Service.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs when prescribed to treat infertility.
- Certain Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.

- A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

APPENDIX A-6 LOSS RATIO SUMMARY OCT-DEC 2017

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
(0162) Emerald Coast Utilities Authority			
January 2017			
MEDICAL	291,407.00		
RX	96,702.00		
TOTAL	388,109.00	630,143.45	61.59%
February 2017			
MEDICAL	381,253.00		
RX	102,996.00		
TOTAL	484,249.00	633,203.56	76.48%
March 2017			
MEDICAL	436,591.00		
RX	97,186.00		
TOTAL	533,777.00	627,774.43	85.03%
April 2017			
MEDICAL	391,579.00		
RX	95,630.00		
TOTAL	487,209.00	624,266.75	78.05%
May 2017			
MEDICAL	562,747.00		
RX	97,506.00		
TOTAL	660,253.00	642,244.70	102.80%
June 2017			
MEDICAL	414,557.00		
RX	99,184.00		
TOTAL	513,741.00	627,619.57	81.86%
July 2017			
MEDICAL	298,153.00		
RX	119,560.00		
TOTAL	417,713.00	631,888.55	66.11%
August 2017			
MEDICAL	400,818.00		
RX	121,430.00		
TOTAL	522,248.00	633,950.22	82.38%
September 2017			
MEDICAL	557,156.00		
RX	143,491.00		
TOTAL	700,647.00	627,847.32	111.60%
October 2017			
MEDICAL	257,986.00		
RX	112,688.00		
TOTAL	370,674.00	656,280.77	56.48%
November 2017			
MEDICAL	408,821.00		
RX	114,975.00		
TOTAL	523,796.00	657,582.03	79.65%
December 2017			

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	457,433.00		
	RX	126,344.00		
	TOTAL	583,777.00	652,002.89	89.54%
GROUP TOTALS	**MEDICAL**	**4,858,501.00**		
	RX	**1,327,692.00**		
	TOTAL	**6,186,193.00**	**7,644,804.24**	**80.92%**

APPENDIX A-7 LOSS RATIO BY PLAN OCT-DEC 2017

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
(0162) Emerald Coast Utilities Authority			
Plan 14			
January 2017			
MEDICAL	197,418.00		
RX	67,289.00		
TOTAL	264,707.00	409,284.58	64.43%
February 2017			
MEDICAL	249,953.00		
RX	85,646.00		
TOTAL	335,599.00	407,007.92	80.41%
March 2017			
MEDICAL	269,503.00		
RX	61,445.00		
TOTAL	330,948.00	398,908.68	76.93%
April 2017			
MEDICAL	206,652.00		
RX	64,443.00		
TOTAL	271,095.00	394,504.56	66.95%
May 2017			
MEDICAL	425,791.00		
RX	62,286.00		
TOTAL	488,077.00	404,992.50	79.07%
June 2017			
MEDICAL	204,387.00		
RX	60,429.00		
TOTAL	264,816.00	394,504.68	55.92%
July 2017			
MEDICAL	158,975.00		
RX	76,090.00		
TOTAL	235,065.00	398,274.30	52.23%
August 2017			
MEDICAL	276,998.00		
RX	78,296.00		
TOTAL	355,294.00	392,489.38	77.74%
September 2017			
MEDICAL	405,690.00		
RX	78,787.00		
TOTAL	484,477.00	390,880.30	100.58%
October 2017			
MEDICAL	132,952.00		
RX	70,935.00		
TOTAL	203,887.00	421,137.54	39.98%
November 2017			

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	263,363.00		
	RX	79,981.00		
	TOTAL	343,344.00	416,700.79	77.44%
December 2017				
	MEDICAL	350,545.00		
	RX	77,865.00		
	TOTAL	428,410.00	407,375.27	100.76%
PLAN TOTALS	**MEDICAL**	**3,142,227.00**		
	RX	**863,492.00**		
	TOTAL	**4,005,719.00**	**4,836,060.50**	**82.83%**

Plan 5

January 2017				
	MEDICAL	93,989.00		
	RX	29,413.00		
	TOTAL	123,402.00	220,858.87	38.81%
February 2017				
	MEDICAL	131,300.00		
	RX	17,350.00		
	TOTAL	148,650.00	226,195.64	59.78%
March 2017				
	MEDICAL	167,088.00		
	RX	35,741.00		
	TOTAL	202,829.00	228,865.75	88.01%
April 2017				
	MEDICAL	184,927.00		
	RX	31,187.00		
	TOTAL	216,114.00	229,762.19	87.76%
May 2017				
	MEDICAL	136,956.00		
	RX	35,220.00		
	TOTAL	172,176.00	237,252.20	65.07%
June 2017				
	MEDICAL	210,170.00		
	RX	38,755.00		
	TOTAL	248,925.00	233,114.89	105.25%
July 2017				
	MEDICAL	139,178.00		
	RX	43,470.00		
	TOTAL	182,648.00	233,614.25	76.79%
August 2017				
	MEDICAL	123,820.00		
	RX	43,134.00		
	TOTAL	166,954.00	241,460.84	66.19%
September 2017				

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	151,466.00		
	RX	64,704.00		
	TOTAL	216,170.00	236,967.02	86.20%
October 2017				
	MEDICAL	125,034.00		
	RX	41,753.00		
	TOTAL	166,787.00	235,143.23	68.90%
November 2017				
	MEDICAL	145,458.00		
	RX	34,994.00		
	TOTAL	180,452.00	240,881.24	73.85%
December 2017				
	MEDICAL	106,888.00		
	RX	48,479.00		
	TOTAL	155,367.00	244,627.62	60.39%
PLAN TOTALS	**MEDICAL**	**1,716,274.00**		
	RX	**464,200.00**		
	TOTAL	**2,180,474.00**	**2,808,743.74**	**77.63%**
GROUP TOTALS	**MEDICAL**	**4,858,501.00**		
	RX	**1,327,692.00**		
	TOTAL	**6,186,193.00**	**7,644,804.24**	**80.92%**

APPENDIX A-8 LOSS RATIO BY PLAN 2016-2017

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
(0162) Emerald Coast Utilities Authority			
Plan 14			
October 2016			
MEDICAL	260,870.00		
RX	79,292.00		
TOTAL	340,162.00	417,973.56	75.23%
November 2016			
MEDICAL	141,848.00		
RX	81,675.00		
TOTAL	223,523.00	409,210.11	53.54%
December 2016			
MEDICAL	252,461.00		
RX	66,256.00		
TOTAL	318,717.00	408,843.76	78.55%
January 2017			
MEDICAL	197,418.00		
RX	67,289.00		
TOTAL	264,707.00	409,284.58	64.43%
February 2017			
MEDICAL	249,953.00		
RX	85,646.00		
TOTAL	335,599.00	407,007.92	80.41%
March 2017			
MEDICAL	269,503.00		
RX	61,445.00		
TOTAL	330,948.00	398,908.68	76.93%
April 2017			
MEDICAL	206,652.00		
RX	64,443.00		
TOTAL	271,095.00	394,504.56	66.95%
May 2017			
MEDICAL	425,791.00		
RX	62,286.00		
TOTAL	488,077.00	404,992.50	79.07%
June 2017			
MEDICAL	204,387.00		
RX	60,429.00		
TOTAL	264,816.00	394,504.68	55.92%
July 2017			
MEDICAL	158,975.00		
RX	76,090.00		
TOTAL	235,065.00	398,274.30	52.23%
August 2017			

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	276,998.00		
	RX	78,296.00		
	TOTAL	355,294.00	392,489.38	77.74%
September 2017				
	MEDICAL	405,690.00		
	RX	78,787.00		
	TOTAL	484,477.00	390,880.30	100.58%
PLAN TOTALS	**MEDICAL**	**3,050,546.00**		
	RX	**861,934.00**		
	TOTAL	**3,912,480.00**	**4,826,874.33**	**81.06%**

Plan 5

October 2016				
	MEDICAL	140,743.00		
	RX	31,071.00		
	TOTAL	171,814.00	220,346.29	65.79%
November 2016				
	MEDICAL	385,806.00		
	RX	34,820.00		
	TOTAL	420,626.00	217,693.54	90.71%
December 2016				
	MEDICAL	265,042.00		
	RX	48,324.00		
	TOTAL	313,366.00	230,212.76	99.09%
January 2017				
	MEDICAL	93,989.00		
	RX	29,413.00		
	TOTAL	123,402.00	220,858.87	38.81%
February 2017				
	MEDICAL	131,300.00		
	RX	17,350.00		
	TOTAL	148,650.00	226,195.64	59.78%
March 2017				
	MEDICAL	167,088.00		
	RX	35,741.00		
	TOTAL	202,829.00	228,865.75	88.01%
April 2017				
	MEDICAL	184,927.00		
	RX	31,187.00		
	TOTAL	216,114.00	229,762.19	87.76%
May 2017				
	MEDICAL	136,956.00		
	RX	35,220.00		
	TOTAL	172,176.00	237,252.20	65.07%
June 2017				

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	210,170.00		
	RX	38,755.00		
	TOTAL	248,925.00	233,114.89	105.25%
July 2017				
	MEDICAL	139,178.00		
	RX	43,470.00		
	TOTAL	182,648.00	233,614.25	76.79%
August 2017				
	MEDICAL	123,820.00		
	RX	43,134.00		
	TOTAL	166,954.00	241,460.84	66.19%
September 2017				
	MEDICAL	151,466.00		
	RX	64,704.00		
	TOTAL	216,170.00	236,967.02	86.20%
PLAN TOTALS	**MEDICAL**	**2,130,485.00**		
	RX	**453,189.00**		
	TOTAL	**2,583,674.00**	**2,756,344.24**	**93.74%**
GROUP TOTALS	**MEDICAL**	**5,181,031.00**		
	RX	**1,315,123.00**		
	TOTAL	**6,496,154.00**	**7,583,218.57**	**85.66%**

APPENDIX A-9 LOSS RATIO SUMMARY 2016-2017

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
(0162) Emerald Coast Utilities Authority			
October 2016			
MEDICAL	401,613.00		
RX	110,363.00		
TOTAL	511,976.00	638,319.85	80.21%
November 2016			
MEDICAL	527,654.00		
RX	116,495.00		
TOTAL	644,149.00	626,903.65	102.75%
December 2016			
MEDICAL	517,503.00		
RX	114,580.00		
TOTAL	632,083.00	639,056.52	98.91%
January 2017			
MEDICAL	291,407.00		
RX	96,702.00		
TOTAL	388,109.00	630,143.45	61.59%
February 2017			
MEDICAL	381,253.00		
RX	102,996.00		
TOTAL	484,249.00	633,203.56	76.48%
March 2017			
MEDICAL	436,591.00		
RX	97,186.00		
TOTAL	533,777.00	627,774.43	85.03%
April 2017			
MEDICAL	391,579.00		
RX	95,630.00		
TOTAL	487,209.00	624,266.75	78.05%
May 2017			
MEDICAL	562,747.00		
RX	97,506.00		
TOTAL	660,253.00	642,244.70	102.80%
June 2017			
MEDICAL	414,557.00		
RX	99,184.00		
TOTAL	513,741.00	627,619.57	81.86%
July 2017			
MEDICAL	298,153.00		
RX	119,560.00		
TOTAL	417,713.00	631,888.55	66.11%
August 2017			
MEDICAL	400,818.00		
RX	121,430.00		
TOTAL	522,248.00	633,950.22	82.38%
September 2017			

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	557,156.00		
	RX	143,491.00		
	TOTAL	700,647.00	627,847.32	111.60%
GROUP TOTALS	**MEDICAL**	**5,181,031.00**		
	RX	**1,315,123.00**		
	TOTAL	**6,496,154.00**	**7,583,218.57**	**85.66%**

APPENDIX A-10 MEMBERSHIP PLAN 5 2016-2017

ECUA Plan 5 Membership Oct 16 - Sept 17

Membership Year/Month	Single Subscribers	plus Spouse	plus Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2016-10	120	26	18	33	197	165	362
2016-11	120	25	18	32	195	161	356
2016-12	127	26	18	32	203	162	365
2017-01	126	27	18	31	202	159	361
2017-02	128	25	18	33	204	163	367
2017-03	131	25	19	31	206	159	365
2017-04	128	27	20	32	207	165	372
2017-05	133	27	20	32	212	167	379
2017-06	132	28	20	31	211	165	376
2017-07	132	28	21	31	212	166	378
2017-08	137	28	23	30	218	165	383
2017-09	139	27	23	30	219	164	383
Total	**1,553**	**319**	**236**	**378**	**2,486**	**1,961**	**4,447**

APPENDIX A-11 MEMBERSHIP PLAN 14 2016-2017

ECUA Plan 14 Membership Oct 16 - Sept 17

Membership Year/Month	Single Subscribers	plus Spouse	plus Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2016-10	242	31	30	63	366	289	655
2016-11	244	29	29	62	364	281	645
2016-12	244	29	30	62	365	284	649
2017-01	241	29	29	61	360	280	640
2017-02	242	29	29	60	360	278	638
2017-03	235	30	30	58	353	272	625
2017-04	235	30	31	57	353	271	624
2017-05	236	32	31	56	355	267	622
2017-06	235	32	31	56	354	267	621
2017-07	234	31	30	56	351	265	616
2017-08	235	28	29	57	349	263	612
2017-09	234	29	29	57	349	264	613
Total	**2,857**	**359**	**358**	**705**	**4,279**	**3,281**	**7,560**

APPENDIX A-12 LARGE CLAIMS PLAN 5 2016-2017

ECUA Plan 5 50K Large Claim Report Oct 16 - Sept 17

Claimant	Employment Status	Medicare Status	Payments
Claimant 1	Active	Non-Medicare	$289,620.99
			$289,620.99
Claimant 2	Active	Non-Medicare	$90,681.02
		Medicare	$31,313.82
			$121,994.84
Claimant 3	Active	Non-Medicare	$115,710.07
			$115,710.07
Claimant 4	Active	Non-Medicare	$92,104.00
			$92,104.00
Claimant 5	Active	Non-Medicare	$84,692.03
			$84,692.03
Claimant 6	Retired	Non-Medicare	$79,233.79
		Medicare	$2,658.06
			$81,891.85
Claimant 7	Active	Non-Medicare	$76,945.98
			$76,945.98
Claimant 8	Retired	Non-Medicare	$72,857.49
			$72,857.49
Claimant 9	Active	Non-Medicare	$61,814.99
			$61,814.99
Claimant 10	Retired	Medicare	$59,370.68
			$59,370.68
Claimant 11	Active	Non-Medicare	$54,118.73
			$54,118.73
Total			**$1,111,121.65**

APPENDIX A-13 LARGE CLAIMS PLAN 14 2016-2017

ECUA Plan 14 50K Large Claim Report Oct 16 - Sept 17

Claimant	Employment St	Medicare Status	Payments
Claimant 1	Active	Non-Medicare	$308,176.06
			$93,933.51
			$402,109.57
Claimant 2	Retired	Non-Medicare	$268,294.44
			$268,294.44
Claimant 3	Active	Non-Medicare	$132,690.50
			$132,690.50
Claimant 4	Active	Non-Medicare	$110,089.57
			$110,089.57
Claimant 5	Active	Non-Medicare	$94,423.03
			$94,423.03
Claimant 6	Active	Non-Medicare	$83,319.11
			$83,319.11
Claimant 7	Active	Non-Medicare	$74,817.70
			$74,817.70
Claimant 8	Active	Non-Medicare	$31,674.43
	Retired	Non-Medicare	$37,827.80
			$69,502.23
Claimant 9	Active	Non-Medicare	$55,337.43
			$55,337.43
Claimant 10	Active	Non-Medicare	$53,433.34
			$53,433.34
Claimant 11	Active	Non-Medicare	$51,029.70
			$51,029.70
Claimant 12	Active	Non-Medicare	$50,966.34
			$50,966.34
Total			**$1,446,012.96**

APPENDIX A-14 LOSS RATIO SUMMARY 2015-2016

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
(0162) Emerald Coast Utilities Authority			
October 2015			
MEDICAL	244,048.00		
RX	93,114.00		
TOTAL	337,162.00	591,356.87	57.01%
November 2015			
MEDICAL	493,217.00		
RX	101,797.00		
TOTAL	595,014.00	589,723.08	100.90%
December 2015			
MEDICAL	346,770.00		
RX	100,996.00		
TOTAL	447,766.00	599,651.75	74.67%
January 2016			
MEDICAL	256,374.00		
RX	94,610.00		
TOTAL	350,984.00	594,441.52	59.04%
February 2016			
MEDICAL	369,657.00		
RX	92,487.00		
TOTAL	462,144.00	605,866.83	76.28%
March 2016			
MEDICAL	436,164.00		
RX	96,676.00		
TOTAL	532,840.00	613,551.06	86.85%
April 2016			
MEDICAL	348,866.00		
RX	94,370.00		
TOTAL	443,236.00	602,516.32	73.56%
May 2016			
MEDICAL	317,272.00		
RX	94,752.00		
TOTAL	412,024.00	603,339.96	68.29%
June 2016			
MEDICAL	419,203.00		
RX	104,743.00		
TOTAL	523,946.00	599,045.49	87.46%
July 2016			
MEDICAL	191,469.00		
RX	117,681.00		
TOTAL	309,150.00	598,583.60	51.65%
August 2016			
MEDICAL	145,494.00		
RX	96,240.00		
TOTAL	241,734.00	589,939.95	40.98%
September 2016			

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	450,930.00		
	RX	92,052.00		
	TOTAL	542,982.00	596,172.41	91.08%
GROUP TOTALS	**MEDICAL**	**4,019,464.00**		
	RX	**1,179,518.00**		
	TOTAL	**5,198,982.00**	**7,184,188.84**	**72.37%**

APPENDIX A-15 MEMBERSHIP PLAN 5 2015-2016

ECUA Plan 5 Membership Oct 15 - Sept 16

Membership Year/Month	Single Subscribers	plus Spouse	plus Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2015-10	100	20	8	31	159	130	289
2015-11	100	19	8	32	159	131	290
2015-12	101	19	8	34	162	136	298
2016-01	100	21	8	34	163	138	301
2016-02	97	22	14	35	168	147	315
2016-03	100	22	14	34	170	145	315
2016-04	99	23	13	32	167	141	308
2016-05	106	26	12	32	176	143	319
2016-06	107	1	1	1	110	3	113
2016-07	109	1	1	1	112	3	115
2016-08	108	1	0	0	109	1	110
2016-09	110	1	0	0	111	1	112
Total	**1,237**	**176**	**87**	**266**	**1,766**	**1,119**	**2,885**

APPENDIX A-16 MEMBERSHIP PLAN 14 2015-2016

ECUA Plan 14 Membership Oct 15 - Sept 16

Membership Year/Month	Single Subscribers	plus Spouse	plus Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2015-10	267	34	30	65	396	294	690
2015-11	270	34	29	65	398	293	691
2015-12	273	33	29	64	399	291	690
2016-01	277	33	30	64	404	291	695
2016-02	270	33	34	65	402	298	700
2016-03	272	33	35	64	404	296	700
2016-04	268	32	35	65	400	297	697
2016-05	267	32	35	64	398	295	693
2016-06	263	31	35	63	392	292	684
2016-07	259	30	34	63	386	291	677
2016-08	261	29	34	63	387	289	676
2016-09	261	29	33	64	387	291	678
Total	**3,208**	**383**	**393**	**769**	**4,753**	**3,518**	**8,271**

APPENDIX A-17 LARGE CLAIMS PLAN 5 2015-2016

ECUA Plan 5 50K Large Claim Report Oct 15 - Sept 16

Claimant	Employment Status	Medicare Status	Payments
Claimant 1	Active	Non-Medicare	$199,351.12
		Medicare	$19,937.26
			$219,288.38
Claimant 2	Active	Non-Medicare	$132,097.75
	Active	Non-Medicare	$648.52
	Retired	Non-Medicare	$70,279.68
			$203,025.95
Claimant 3	Active	Non-Medicare	$191,556.27
			$191,556.27
Claimant 4	Active	Non-Medicare	$137,714.48
			$137,714.48
Claimant 5	Retired	Non-Medicare	$71,718.17
			$71,718.17
Claimant 6	Active	Non-Medicare	$71,564.30
			$71,564.30
Claimant 7	Active	Non-Medicare	$63,597.30
			$63,597.30
Total			**$958,464.85**

APPENDIX A-18 LARGE CLAIMS PLAN 14 2015-2016

ECUA Plan 14 50K Large Claim Report Oct 15 - Sept 16

Claimant	Employment Sta	Medicare Status	Payments
Claimant 1	Active	Non-Medicare	$138,925.43
			$138,925.43
Claimant 2	Active	Non-Medicare	$132,378.24
			$132,378.24
Claimant 3	Active	Non-Medicare	$109,487.09
			$109,487.09
Claimant 4	Active	Non-Medicare	$55,126.54
			$55,126.54
Claimant 5	Active	Non-Medicare	$51,945.60
			$51,945.60
Claimant 6	Active	Non-Medicare	$50,539.20
			$50,539.20
Total			**$538,402.10**

APPENDIX A-19 LOSS RATIO SUMMARY 2014-2015

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
(0162) Emerald Coast Utilities Authority			
October 2014			
MEDICAL	351,863.00		
RX	100,134.00		
TOTAL	451,997.00	491,168.56	92.02%
November 2014			
MEDICAL	366,624.00		
RX	83,852.00		
TOTAL	450,476.00	501,288.72	89.86%
December 2014			
MEDICAL	309,505.00		
RX	110,021.00		
TOTAL	419,526.00	503,449.42	83.33%
January 2015			
MEDICAL	277,660.00		
RX	101,143.00		
TOTAL	378,803.00	494,508.74	76.60%
February 2015			
MEDICAL	235,612.00		
RX	128,742.00		
TOTAL	364,354.00	505,961.28	72.01%
March 2015			
MEDICAL	429,601.00		
RX	100,414.00		
TOTAL	530,015.00	520,501.22	101.83%
April 2015			
MEDICAL	325,948.00		
RX	112,796.00		
TOTAL	438,744.00	528,384.34	83.04%
May 2015			
MEDICAL	308,637.00		
RX	84,641.00		
TOTAL	393,278.00	528,925.38	74.35%
June 2015			
MEDICAL	471,818.00		
RX	102,092.00		
TOTAL	573,910.00	533,995.34	107.47%
July 2015			
MEDICAL	471,461.00		
RX	81,167.00		
TOTAL	552,628.00	535,222.76	103.25%
August 2015			
MEDICAL	434,527.00		
RX	91,805.00		
TOTAL	526,332.00	528,567.72	99.58%
September 2015			

	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	306,508.00		
	RX	85,008.00		
	TOTAL	391,516.00	529,004.98	74.01%
GROUP TOTALS	**MEDICAL**	**4,289,764.00**		
	RX	**1,181,815.00**		
	TOTAL	**5,471,579.00**	**6,200,978.46**	**88.24%**

APPENDIX A-20 MEMBERSHIP PLAN 5 2014-2015

ECUA Plan 5 Membership By Month Oct 14-Sept 15

Membership Year/Month	Single	Subscribers plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2014-10	81	16	3	27	127	115	242
2014-11	83	16	3	27	129	113	242
2014-12	83	16	3	27	129	113	242
2015-01	86	14	2	28	130	112	242
2015-02	92	15	2	31	140	121	261
2015-03	91	15	3	31	140	123	263
2015-04	93	14	6	31	144	125	269
2015-05	95	14	6	31	146	125	271
2015-06	94	13	6	30	143	122	265
2015-07	94	14	6	30	144	123	267
2015-08	92	15	6	30	143	124	267
2015-09	93	15	6	31	145	127	272
Total	**1,077**	**177**	**52**	**354**	**1,660**	**1,443**	**3,103**

APPENDIX A-21 MEMBERSHIP PLAN 14 2014-2015

ECUA Plan 14 Membership By Month Oct 14-Sept 15

Membership Year/Month	Single	Subscribers plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2014-10	264	35	25	61	385	264	649
2014-11	266	36	27	61	390	266	656
2014-12	265	36	27	60	388	264	652
2015-01	269	37	24	60	390	260	650
2015-02	277	37	26	60	400	266	666
2015-03	279	37	27	65	408	287	695
2015-04	274	36	29	66	405	293	698
2015-05	275	37	29	66	407	294	701
2015-06	274	36	28	65	403	289	692
2015-07	275	35	27	66	403	289	692
2015-08	273	35	27	69	404	299	703
2015-09	275	35	27	69	406	299	705
Total	**3,266**	**432**	**323**	**768**	**4,789**	**3,370**	**8,159**

APPENDIX A-22 LARGE CLAIMS PLAN 5 2014-2015

ECUA 50K Large Claim Plan 5 Oct14-Sept15

Claimant	Employment Status	Medicare Status	Payments
Claimant 1	Active	Non-Medicare	$154,399.69
			$154,399.69
Claimant 2	Active	Non-Medicare	$103,610.90
		Medicare	$13,560.12
			$117,171.02
Claimant 3	Active	Non-Medicare	$111,199.25
			$111,199.25
Claimant 4	Active	Non-Medicare	$94,724.78
			$94,724.78
Claimant 5	Retired	Non-Medicare	$50,836.54
		Medicare	$217.04
			$51,053.58
Total			**$528,548.32**

APPENDIX A-23 LARGE CLAIMS PLAN 14 2014-2015

ECUA 50K Large Claim Plan 14 Oct14-Sept15

Claimant	Employment Status	Medicare Status	Payments
Claimant 1	Active	Non-Medicare	$227,332.16
			$227,332.16
Claimant 2	Active	Non-Medicare	$195,064.26
			$195,064.26
Claimant 3	Active	Non-Medicare	$123,295.38
		Medicare	$58,094.60
			$181,389.98
Claimant 4	Active	Non-Medicare	$166,058.19
			$166,058.19
Claimant 5	Active	Non-Medicare	$129,161.12
			$129,161.12
Claimant 6	Active	Non-Medicare	$114,933.37
			$114,933.37
Claimant 7	Active	Non-Medicare	$100,185.85
			$100,185.85
Claimant 8	Active	Non-Medicare	$97,131.01
			$97,131.01
Claimant 9	Active	Non-Medicare	$81,199.20
			$81,199.20
Claimant 10	Active	Non-Medicare	$81,126.73
			$81,126.73
Claimant 11	Active	Non-Medicare	$64,929.70
			$64,929.70
Claimant 12	Active	Non-Medicare	$64,424.45
			$64,424.45
Claimant 13	Active	Non-Medicare	$54,558.66
			$54,558.66
Claimant 14	Active	Non-Medicare	$47,518.95
	Active	Non-Medicare	$1,129.86
	Retired	Non-Medicare	$1,707.00
			$50,355.81
Total			**$1,607,850.49**

APPENDIX B-1 DENTAL PLAN OPTIONS 2017-2018 SCHEDULE OF BENEFITS

Emerald Coast Utilities Authority

Dental Highlight Sheet

Policy #754268

Network: Classic (PPO)

Low Option - Plan A: Dental Summary

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Plan Year Type 2 & 3
	Waived Type 1
	$100/family
Maximum *(per person)*	$1,000 per Plan year
Max Keeper	Included
Allowance	90th U&C
Max Builder[SM]	Included
Waiting Period	None
Annual Open Enrollment	Included

Orthodontia Summary

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 in 12 months)	• Space Maintainers	• Onlays
• Bitewing X-rays (1 in 12 months)	• Restorative Amalgams	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 5 years)	• Restorative Composites	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Periapical X-rays	• Crown Repair	
• Cleaning (2 in 12 months)	• Endodontics (nonsurgical)	
• Fluoride for Children 18 and under (2 in 12 months)	• Endodontics (surgical)	
• Sealants (age 15 and under)	• Periodontics (nonsurgical)	
	• Periodontics (surgical)	
	• Denture Repair	
	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Emerald Coast Utilities Authority
Dental Highlight Sheet
Policy #754268

Claims Customer Service

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

Max Keeper

With this plan option, benefits for Type 1/Preventive procedures are not deducted from the plan participant's annual maximum benefit. This saves the entire annual maximum for the Type 2/Basic and Type 3/Major procedures that are covered by your plan.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist." California Residents: When prompted to select your network, choose Classic (PPO).

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Emerald Coast Utilities Authority
Dental Highlight Sheet
Policy #754268

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

Emerald Coast Utilities Authority

Dental Highlight Sheet

Policy #754268

Network: Classic (PPO)

High Option - Plan B: Dental Summary

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Plan Year Type 2 & 3
	Waived Type 1
	$100/family
Maximum *(per person)*	$1,500 per Plan year
Max Keeper	Included
Allowance	90th U&C
Max Builder[SM]	Included
Waiting Period	None
Annual Open Enrollment	Included

Orthodontia Summary

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,500
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 in 12 months)	• Space Maintainers	• Onlays
• Bitewing X-rays (1 in 12 months)	• Restorative Amalgams	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 5 years)	• Restorative Composites	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Periapical X-rays	• Crown Repair	
• Cleaning (2 in 12 months)	• Endodontics (nonsurgical)	
• Fluoride for Children 18 and under (2 in 12 months)	• Endodontics (surgical)	
• Sealants (age 15 and under)	• Periodontics (nonsurgical)	
	• Periodontics (surgical)	
	• Denture Repair	
	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Emerald Coast Utilities Authority
Dental Highlight Sheet
Policy #754268

Claims Customer Service

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

Max Keeper

With this plan option, benefits for Type 1/Preventive procedures are not deducted from the plan participant's annual maximum benefit. This saves the entire annual maximum for the Type 2/Basic and Type 3/Major procedures that are covered by your plan.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist." California Residents: When prompted to select your network, choose Classic (PPO).

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Emerald Coast Utilities Authority
Dental Highlight Sheet
Policy #754268

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

APPENDIX B-2 DENTAL PLAN CLAIMS VS PREMIUM

EMERALD COAST UTILITIES AUTHORITY

Monthly Experience Summary

Policy #: 754268 *10/01/2016 through 01/31/2018*

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
DEN	Jan 2018	$24,437	$20,740	85%	643	286
DEN	Dec 2017	$23,883	$23,871	100%	633	284
DEN	Nov 2017	$24,366	$27,451	113%	639	286
DEN	Oct 2017	$24,309	$25,131	103%	638	287
DEN	Sep 2017	$24,270	$30,489	126%	645	286
DEN	Aug 2017	$24,321	$25,394	104%	640	287
DEN	Jul 2017	$24,085	$22,624	94%	635	289
DEN	Jun 2017	$24,098	$23,433	97%	637	287
DEN	May 2017	$24,355	$26,468	109%	641	288
DEN	Apr 2017	$24,020	$25,062	104%	632	286
DEN	Mar 2017	$23,877	$27,022	113%	631	281
DEN	Feb 2017	$23,742	$23,952	101%	634	283
DEN	Jan 2017	$23,433	$20,996	90%	636	287
DEN	Dec 2016	$24,641	$18,713	76%	644	290
DEN	Nov 2016	$23,454	$18,649	80%	629	286
DEN	Oct 2016	$24,566	$13,104	53%	633	299
** DEN		$385,856	$373,098		10,190	4,592

APPENDIX C-1 VISION PLAN SCHEDULE OF BENEFITS

Emerald Coast Utilities Authority
Eye Care Highlight Sheet
Policy #754268

Balanced Care Vision I Plan Summary

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam $10 Eye Glass Lenses or Frames*	$10 Exam $10 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to $60	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frames	$130**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco allowance will be the wholesale equivalent.*

Lens Options (participant cost)*

	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses (Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option participant costs vary by prescription, option chosen and retail locations.*

Emerald Coast Utilities Authority
Eye Care Highlight Sheet
Policy #754268

Additional Balanced Care Vision I Choice Network Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Retail Chain Affiliate Providers Available With Balanced Care Vision I Plans

Effective January 1, 2012, retail chain affiliate providers, which include Costco® Optical and Visionworks, give participants added convenience and additional retail choices. Costco Optical has 400 locations across the country, while Visionworks manages nearly 400 optical stores in 37 states and DC, including well-known stores such as EyeMasters, Visionworks, Dr. Bizer's VisionWorld, Eye DRx, and Hour Eyes, to name a few. Participants enjoy a covered-in-full benefit experience with equivalent frame benefit at any of these retail chain locations.

Eye Care Plan Participant Service

Balanced Care Vision I eye care from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: standard.com/services
View plan benefit information at: vsp.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

APPENDIX C-2 VISION PLAN CLAIMS VS PREMIUM

EMERALD COAST UTILITIES AUTHORITY

Monthly Experience Summary

Policy #: 754268 10/01/2016 through 01/31/2018

LOB	Month	Premium $	Paid Claims $	Paid L/R	EE Lives	Dep Units
VIS	Jan 2018	$2,962	$1,554	52%	350	160
VIS	Dec 2017	$2,881	$1,837	64%	345	158
VIS	Nov 2017	$2,868	$2,129	74%	347	157
VIS	Oct 2017	$2,956	$1,571	53%	343	156
VIS	Sep 2017	$2,819	$2,095	74%	337	155
VIS	Aug 2017	$2,843	$2,381	84%	335	157
VIS	Jul 2017	$2,822	$1,655	59%	333	158
VIS	Jun 2017	$2,841	$3,725	131%	333	156
VIS	May 2017	$2,815	$2,010	71%	331	155
VIS	Apr 2017	$2,753	$1,411	51%	322	154
VIS	Mar 2017	$2,753	$1,634	59%	320	153
VIS	Feb 2017	$2,754	$2,706	98%	323	154
VIS	Jan 2017	$2,684	$1,988	74%	321	155
VIS	Dec 2016	$2,851	$2,032	71%	328	158
VIS	Nov 2016	$2,763	$1,350	49%	318	155
VIS	Oct 2016	$2,753	$0	0%	318	154
** VIS		$45,118	$30,077		5,304	2,495
TOTAL		$430,974	$403,175		15,494	7,087

Paid Claims : $403,175 Change in Reserves: $15,289 = Incurred Claims: $418,464

** Incurred Claims = Paid Claims + Change in Reserves